PERSONAL INJURY QUESTIONNAIRE

NAME_____ TODAY'S DATE_____

DATE OF INJURY/ACCIDENT_____ PLACE OF INJURY_____

YOUR ADDRESS_____CITY_____STATE_____

ZIP CODE_____YOUR INSURANCE COMPANY_____

CLAIM#_____ADJUSTER'S NAME_____

ADJUSTER'S PHONE NUMBER_____DO YOU HAVE AN ATTORNEY?( )YES ( ) NO

IF YES, **ATTORNEY'S NAME**, **ADDRESS AND PHONE NUMBER**_____

_____

WERE THERE ANY WITNESSES? ( )YES ( ) NO NAMES_____

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:_____

_____

_____

_____

_____

DID YOU GET ANY BLEEDING CUTS? _____ WHERE_____

DID YOU GET ANY BRUISES?_____WHERE?_____

DID YOU LOSE CONCIOUSNESS AT ANY TIME DURING OR AFTER THE ACCIDENT?_____

IF YES, FOR HOW LONG?_____ WERE THE POLICE NOTIFIED?_____

DID THEY COME TO THE SCENE OF THE ACCIDENT?_____WERE YOU TAKEN TO THE HOSPITAL_____WHICH ONE_____HOW DID YOU GET THERE?_____

WHAT PARTS OF YOUR BODY WERE X-RAYED_____CAT SCAN?_____

DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE ACCIDENT?_____IF YES, PLEASE LIST OR DESCRIBE_____

_____

HOW DID YOU FEEL…

(A) DURING THE ACCIDENT_____

(B) IMMEDIATELY AFTER THE ACCIDENT_____

(C) LATER THAT DAY_____

(D)THE NEXT DAY_____

WHAT ARE YOUR PRESENT COMPLAINTS AND SYMPTOMS? PLEASE BE AS SPECIFIC AS POSSIBLE_____

_____

_____

_____

DO YOU HAVE ANY CONGENITAL CONDITIONS (FROM BIRTH) WHICH COULD RELATE TO THIS PROBLEM?_____

IF YES, PLEASE DESCRIBE_____

HAVE YOU EVER BEEN INVOLVED IN AN ACCIDENT BEFORE?_____IF YES, PLEASE (A) DESCRIBE THE ACCIDENT, (B)THE APPROXIMATE DATE AND (C) INCLUDE ANY INJURIES SUSTAINED_____

_____

_____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR SINCE THIS ACCIDENT OCCURRED?_____IF YES, WHO?_____

WHAT DID THEY DO?_____

SINCE YOUR INJURY, ARE YOUR SYMPTOMS (CHECK ONE) ( )GETTING WORSE ( )STAYING THE SAME ( )IMPROVING

PLEAE CHECK OFF THE SYMPTOMS THAT YOU HAVE NOTICED <u>SINCE THE ACCIDENT</u>:

( ) HEADACHE ( ) IRRITABILITY ( ) NUMBNESS ( ) CHEST PAIN

( ) FACE FLUSHED ( ) FEET COLD ( ) NECK PAIN ( ) SHORTNESS OF BREATH

( ) BUZZING IN EARS ( ) HANDS COLD ( ) NECK STIFF ( ) DIZZINESS

( ) FATIGUE ( ) LOSS OF BALANCE ( ) STOMACH UPSET ( ) SLEEPING PROBLEMS

( ) DEPRESSION ( ) FAINTING ( ) CONSTIPATION ( ) BACK PAIN

( ) LOSS OF SMELL ( ) COLD SWEATS ( ) PINS/NEEDLES IN ARMS ( ) PINS/NEEDLES IN LEGS

( ) NERVOUSNESS ( ) LOSS OF MEMORY( ) LOSS OF TASTE ( ) FEVER

( ) ANXIETY ( ) TENSION ( ) BLURRED VISION ( ) LIGHT SENSITIVITY

( ) EARS RINGING ( ) NUMBNESS IN EXTREMITIES

ANY ADDITIONAL SYMPTOMS:_____

HAVE YOU LOST TIME FROM WORK AS A RESULT OF THIS ACCIDENT? ( ) YES ( ) NO

IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:

(A) LAST DAY WORKED:_____

(B) TYPE OF EMPLOYMENT:_____

(C) PRESENT SALARY:_____

(D) ARE OYU BEING COMPENSATED FOR THE LOST TIME FROM WORK?_____

IF YES, PLEASE STATE THE TYPE OF COMPENSATION YOU ARE RECEIVING:_____

DO YOU NOTICE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? IF YES, PLEASE DESCRIBE:_____

_____

********** IF YOU WERE INVOLVED IN AN AUTO ACCIDENT, PLEASE CONTINUE**********

NAME OF DRIVER AT FAULT:_____NAME OF OTHER DRIVER_____

OTHER DRIVER'S INSURANCE COMPANY_____POLICY #_____

CLAIM NUMBER_____DATE OF ACCIDENT_____TIME_____

STREET OF ACCIDENT_____CITY_____

WHAT WERE THE ROAD CONDITIONS LIKE AT THE TIME OF THE ACCIDENT? ( )ICY ( )WET ( ) RAINY ( )DRY

WEATHER CONDITIONS:_____

WERE YOU: ( ) DRIVER ( ) PASSENGER ( ) FRONT SEAT ( ) BACK SEAT

NUMBER OF PEOPLE IN YOUR VEHICLE INCLUDING YOURSELF_____OTHER VEHICLE_____

WERE YOU SEATED IN THE VEHICLE?_____

WHICH DIRECTION WERE YOU HEADED? ( ) NORTH ( ) SOUTH ( ) EAST ( ) WEST

WHICH DIRECTION WERE YOU STRUCK FROM?: _____

WERE YOU AWARE OF THE APPROACHING COLLISION PRIOR TO THE IMPACT?_____

HOW FAR WAS THE TOP OF THE HEADREST OR SEATBACK FROM THE TOP OF YOUR HEAD?

( ) INCHES ABOVE YOUR HEAD ( ) INCHES BELOW YOUR HEAD

WERE YOU WEARING A SEATBELT? ( ) YES ( ) NO LAP ONLY OR SHOULDER AND LAP?_____

WHAT IS THE YEAR, MAKE AND MODEL OF YOUR VEHICLE?_____

WHAT IS THE YEAR MAKE AND MODEL OF THE OTHER VEHICLE?_____

WAS YOUR CAR STATIONARY AT THE TIME OF THE IMPACT? ( ) YES ( ) NO

IF YES, WAS THE DRIVER'S FOOT ON THE BRAKE? ( ) YES ( ) NO

IF YOUR VEHICLE WAS MOVING, AT WHAT SPEED?_____MPH

AT THE TIME OF THE ACCIDENT, WHICH PART OF THE VEHICLE DID THE FOLLOWING BODY PARTS COME INTO CONTACT WITH/ OR HIT:

(A) HEAD:_____

(B) CHEST:_____

(C) RIGHT/LEFT SHOULDER:_____

(D) RIGHT/LEFT ARM:_____

(E) RIGHT/LEFT LEG:_____

(F) RIGHT/LEFT KNEE:_____

(G) RIGHT/LEFT HIP:_____

(H) OTHER:

WHERE DID YOU FEEL THE IMPACT THE MOST?_____

WHAT, IF ANY WAS THE DAMAGE COST TO YOUR VEHICLE? $_____

WHICH, IF ANY, OF THE FOLLOWING CAR PARTS BROKE DURING THE ACCIDENT?

(A) WINDSHIELD _____ (B) RIGHT OR LEFT SIDE WINDOW_____ (C) STEERING WHEEL_____

(D) FRONT SEAT BACK _____ (E) OTHER_____ (F) OTHER_____

WAS YOUR HEAD POSITIONED STRAIGHT FORWARD? ( ) YES ( ) NO IF NO, WHAT DIRECTION WAS IT TURNED?

IS THERE ANY OTHER INFORMATION YOU'D LIKE TO SHARE THAT MAY BE IMPORTANT FOR YOUR TREATMENT IN THIS OFFICE?_____
_____
_____
_____
_____
_____

OFFICE NOTES:_____
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_____

I (PRINT NAME)_____ SWEAR THAT THE INFORMATION ON THESE FORMS AND PERTAINING TO THIS ACCIDENT/INJURY ARE TRUE AND I HAVE PRESENTED ALL RELEVANT INFORMATION TO THIS OFFICE.

X_____DATE_____